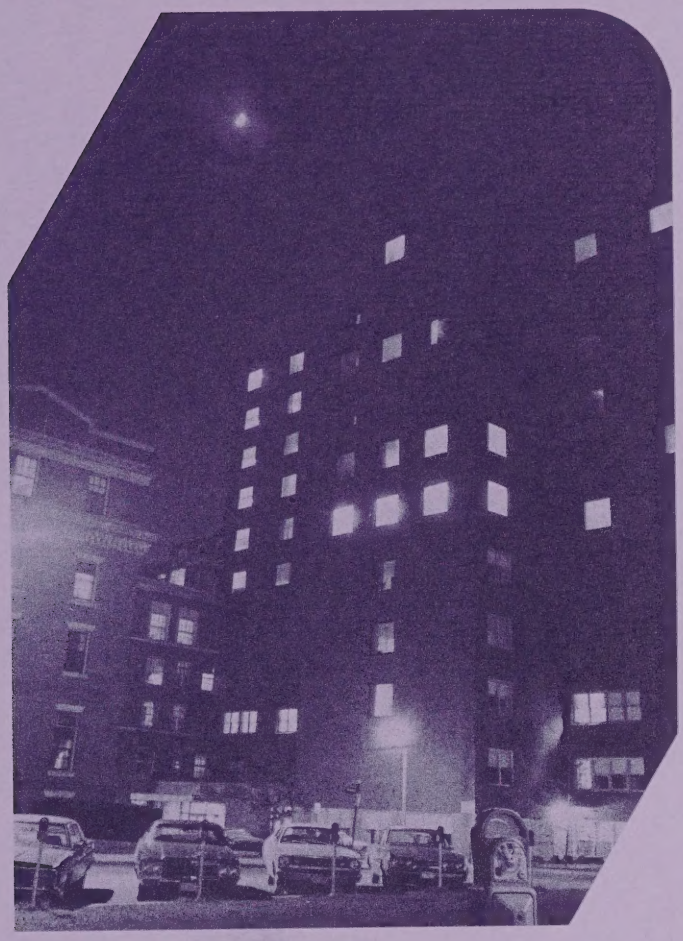
Annual Report 1972



New England Deaconess Hospital

March 1973

New England Deaconess Hospital Directory

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ADDITIONS

THE NEW ENGLAND DEACONESS HOSPITAL

is affiliated with Harvard Medical School and is:

fully accredited by:
THE JOINT COMMISSION ON
ACCREDITATION OF HOSPITALS

member of:
AMERICAN HOSPITAL ASSOCIATION
NEW ENGLAND HOSPITAL ASSEMBLY
MASSACHUSETTS HOSPITAL ASSOCIATION
GREATER BOSTON HOSPITAL ASSOCIATION

residency programs approved by AMERICAN MEDICAL ASSOCIATION: internal medicine, pathology, radiology, surgery and thoracic surgery.

school of nursing fully accredited by:
NATIONAL LEAGUE FOR NURSING
MASSACHUSETTS BOARD OF
REGISTRATION IN NURSING

school for x-ray technicians approved by:
AMERICAN MEDICAL ASSOCIATION

school of medical technology approved by:
AMERICAN SOCIETY OF
CLINICAL PATHOLOGISTS

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New England Deaconess Hospital

Cancer Research Institute
Shields Warren Radiation Laboratory
Medical Office Building
and affiliated clinics.
Joslin Clinic
Lahey Clinic Foundation
Overholt Thoracic Clinic

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The President's Message

Laurens MacLure
President

Concluding my annual report for Fiscal 1971, I stated that these are challenging and exciting times. In my report for Fiscal 1972, I propose to review the last 12 months in terms of that statement and at the same time examine some of the implications for the years immediately ahead.

Because of the new beds which had been opened in the preceding fiscal year, we started with a staff significantly larger than before and with an operating budget about 35 per cent higher. Occupancy was running slightly below 90 per cent for the first time in more than 10 years. Wages and prices were frozen until mid-November. Thus, there was far more than the usual degree of uncertainty surrounding our budget projections.

As the year wore on, however, a fortunate pick-up in occupancy, coupled with good control of

expenses, led to an excess of revenue over expense of $100,000.

As we enter Fiscal 1973 we continue to face financial uncertainty. As is true of other hospitals, we are operating without a Blue Cross contract and, of course, have no way of knowing exactly what basis of reimbursement will ultimately be approved by the Massachusetts Rate Setting Commission. Also, wages and prices continue to be regulated under Phase II. Our budget committee has approved a balanced budget for the current year, but it is predicated on our being granted a modest exception to price guidelines for which we have filed.

In early June we completed construction of the first Phase II facility of our development program — a 415-car garage on the corner of Pilgrim Road and Longwood Avenue. The garage not only will relieve the acute pressure for parking space for our employees, medical staff and visitors, it will make possible planned additions to our current plant, which would not otherwise receive approval from various certifying authorities.

By early next year the plans and specifications for a $5 million laboratory building will be ready to go out for bids. This building will contain modern laboratories for the department of pathology, which are long overdue and also provide the department — the fastest growing department in the hospital — with room for expansion. The basement area of the building will be designed to house our radiation equipment and thus allow us to serve the growing number of patients who are coming to the Deaconess for radiation therapy. We have filed for a certificate of necessity which is required before construction can commence and hope to receive approval to proceed by the time we are ready to go out for bids.

Our building committee is continuing to examine various proposals relating to new quarters for our School of Nursing and a final recommendation is scheduled to be presented to our trustees within the next 12 months.

With the completion of these projects, I believe that we will see a sharp slowdown in the expansion of our physical facilities. Over the remainder of this decade it appears likely that we will turn our efforts to the reorganization and improvement of our services. As we know, hospitals have become subject to (or the subject of) more and more scrutiny and regulation over recent years. Many observers agree that our health care system is inefficient and therefore costly. Many, if not most, believe national health insurance is inevitable. We must, therefore, respond appropriately to the changes that are bound to take place, not only in the health care system particularly but in our society generally.

Indeed, a start has been made. We set up a long range planning committee two years ago and this committee, which is composed of trustees, members of our medical staff and administration, met frequently during the last year. In June it reached the following conclusions: that the climate did not exist that would allow for merger with the Lahey Clinic; that the future of the Deaconess lies in the area of a speciality referral hospital; that such a future will require a gradually increasing interaction or affiliation with a medical school and that a more cohesive organization of the independent medical staff will be necessary to meet the evolving medical needs of society. The discussions of this committee have already led to a positive "fall out" in terms of changing perceptions of the hospital and the responsibilities of those associated with it. Sub-committees are actively examining the implications of the specific recommendations mentioned above.

This is my last report as president of the Deaconess Hospital Corporation and I wish to take the opportunity to thank the thousands of individuals who have helped the New England Deaconess Hospital during my term in office. This includes those who have devoted their time, talents and their energies, as well as those who have been generous in a financial sense. This includes doctors, nurses, department heads — in fact, the entire hospital staff — the Friends of the Deaconess and all our other volunteers. I am especially grateful for the dedication which our trustees, executive committee and corporation members have always demonstrated in so many varied ways to our hospital. Lastly, a special word of appreciation is due Mr. R. D. Lowry, our executive vice president. His vision, determination and firm guidance have played a vital role in making the Deaconess what it is today — one of the finest specialty referral hospitals in the nation.

The Executive Vice President's Message

R. D. Lowry
Executive Vice President

Pressure continues unabated. The addition to our hospital was completed during the past year, over 100 additional beds have been put into service, but our waiting list still exists. The demand for services provided by the hospital continues at a high level.

During the year, we admitted 13,743 patients as compared with 11,845 admitted during 1971. In the past two years our length of stay has been reduced and the shortened length of stay has increased the activity in many departments. In addition, the increase in the total number of beds has added to the workload of all departments, particularly taxing those with inadequate space.

While many departments need space for expansion, the laboratories and radiation therapy departments are the most severely handicapped. In the fifteen years preceding the opening of the additional beds, the laboratories experienced a 425% increase in workload, and in the past five years the number of radiation therapy treatments have more than trebled. The need for a new facility to house these two departments has been stressed in reports from the Joint Commission on Accreditation of Hospitals, the American Society of Clinical Pathologists and data from the American Cancer Society. However, the project has been delayed by the new legislation which makes it necessary for hospitals to obtain a "Determination of Need" certificate for any project that costs $100,000 or more. Our application was submitted last May, but to date the Public Health Council has taken no action. While the legislation has its merits, our hospital is no longer able to respond as quickly as we have in the past to some urgent needs of the departments. For example, the preparation of the application required the full time of one person from administration for over two months, over a hundred hours of time of members of the medical staff from the departments of pathology and therapeutic radiology and an equal number of hours of other key personnel.

With each passing day the administration of hospitals is becoming more complex, and for those of us who spend our full time in this field it is a challenge to find time to read the constant stream of new directives, regulations and legislation that has been enacted.

There was a time when administration was able to keep our trustees well informed about the activities in each department of the hospital. Because of the many complex problems now facing hospitals this is no longer possible, and at meetings of the executive committee of the board of trustees there is time to discuss only the most important problems. Far more time is required of the officers of the corporation, and the chairman of the board and the president generally devote some time of each day to hospital affairs.

One of the important problems facing hospitals is the current wage and price freeze which has had a tremendous impact on financial management. Decisions for which the board of trustees were responsible in the past have now been taken over by the government through the Federal Pay Board and Price Commission.

There are many expenses over which the hospital has no control. During the past year the cost of food, steam, chilled water, Blue Cross coverage, telephone service, medical and surgical supplies and many other items increase. In addition, at the calendar year the nation's hospitals were placed under the unemployment compensation program. The cost of these items alone totaled over one-half

million dollars to which we must add the expenditures for salary increases and replacement of equipment which has become obsolete. New methods which have been developed to improve patient care often create a need for more technical personnel and additional facilities. However, arbitrary constraints on income imposed by the U.S. Price Commission pose a serious threat to our ability to continue providing high quality care to all of our patients.

There is a common misconception that by limiting the dollars a hospital has to spend, the cost of medical care can be controlled. Uninformed members of the general public look at the annual increases in per diem reimbursement and attribute them to inflation. The casual observer concludes that he is paying ten to fifteen percent more for the same hospital service each year. This is inaccurate. The cost of providing the same service is now increasing between five to six percent a year, and the rest represents new services and technologically-improved services.

If the present rigid controls continue, the quality of care will deteriorate and some services may have to be discontinued. The public is not yet aware of the lower quality of medical care they will receive as a result of the government's attempt to put an arbitrary ceiling on hospital charges at a time when the expenses over which the hospital has no control continue to increase.

Dr. William Meissner, who has been with the department of pathology for thirty years and its chairman since 1963, asked to be relieved of administrative responsibilities as of January 1973. While he will continue as pathologist-in-chief, Dr. Bradley Copeland has been appointed chairman of the department and will be responsible for its administration.

There are sixty schools of nursing in Massachusetts including those with diploma, baccalaureate or associate degree programs. To qualify for their registration, graduates of all schools take the same examination given by the Commonwealth. The examination is divided into five sections, medical nursing, surgical nursing, pediatric nursing, psychiatric nursing and obstetrical nursing. In the examination given last fall, our students ranked first in medical, first in surgical, third in pediatrics, fifth in psychiatric and thirteenth in obstetrics. Graduates of this class were the highest ranking of any school or college in Massachusetts. This is a credit to both the faculty and the students since the school is operating in a physical plant that was completed forty-five years ago and is totally inadequate for a school of the 1970's. Plans are being developed for a new facility made possible by a grant from the Kennedy Foundation.

In January Miss Ellen Adams was appointed associate director, and Mr. Peter Campisano and Mr. Robert Pence were appointed assistant directors.

The Friends of the Deaconess continue to be active and a great support to the hospital. In 1971 they made a pledge of $100,000 to assist in the cost of construction of the new radiation therapy department. This pledge was paid in full in just one year, a remarkable achievement.

The new 415-car garage on the corner of Longwood Avenue and Autumn Street was completed during the year, and the total project cost was $2,500,000.

On October first the addition to the Central Building will be dedicated and the building will be renamed the "Farr Memorial Building" in honor of Frederick J. and Frank E. Farr whose bequest of $3,500,000 enabled us to undertake this project. It is appropriate that the speaker will be Bishop John Wesley Lord who, as president of the hospital when the Central Building was completed, presided at the dedication in June of 1953.

During the past year the long-range planning committee has held many meetings and, in addition, members of the board of trustees, medical staff and administration have spent an untold number of hours attempting to formulate recommendations for the future course of our hospital. This is a time of transition for the entire hospital field, and transition brings change which many naturally resist. Strong outside forces are being brought to bear upon hospitals and we have no time to waste. We must be adaptable to change and receptive to innovation so that we will be able to meet the challenges and resolve the problems which now confront us. We must be flexible enough in our thinking to cope with health care problems of the 1980's.

The Department of Medicine

James L. Tullis, M.D.
Chairman

The number of patients admitted to the medical service of the Deaconess increased again in Fiscal 1972, continuing a trend which began about a decade ago. Simultaneously, the percentage of such patients covered by the house staff increased. At the urging of the senior staff, this coverage has been increased annually. The beginning was made a few years ago with coverage of all admissions of the Independent Staff. It then increased to include the total Lahey medical admissions in mid-1972 and went on to cover approximately half of the Joslin patients by the end of 1972. Full coverage of the Joslin patients is tentatively scheduled for mid-1974. These increases now make the Deaconess medical service the second largest in any hospital in New England.

Size alone does not assure quality. Owing to the economic stringencies which hospitals face, the increases in service have not been accompanied by equal increases in the size of the intern-resident staff. The ratio of patients to medical house officers assigned to floor duty has now

reached 14:1, even when areas of concentrated care such as the coronary unit are included. This is as heavy an assignment as can be carried safely in an active general hospital without curtailing emergency care, or the night and weekend coverage which patients and staff have grown to expect.

The educational portion of the training program received a tri-annual review last year while the chairman was on a leave of absence and the department was under the able interim leadership of Dr. Lyman Hoyt. Once again full accreditation was awarded. The absence of adequate outpatient experience was the only deficiency noted. Arrangements to overcome this defect subsequently were made with the Peter Bent Brigham Hospital.

In line with the increasing interrelationship of the Deaconess with other hospitals of the Harvard complex, an agreement also has been completed for rotation of a senior assistant medical resident from the Brigham to the Deaconess and an exchange of junior assistant residents with the Boston City Hospital in certain subspecialties in which the Deaconess has access to a wealth of clinical material and teaching talent.

The presence of strong medical teaching resources at the Deaconess is clearly evident in the burgeoning number of applicants to the house officer program and the peer support which it receives. With no formal system of recruitment and with no designated referrals from the Harvard Medical School, the applications for the internship year rose from none in 1966, which was the first year of the program, to 208 who were asked to come for interviews for the 14 available openings in 1972. There were smaller but equally impressive gains in the resident applicants. Such a trend runs clearly contrary to national statistics which show about half of the intern and residency appointments still unfilled.

What can the Deaconess do to solidify this position? Primarily, it must seek a source of financing from the private sector for the purely educational aspects of its training programs. It is appropriate for government and third-party carriers to support the service portions of the house officers' assignments. Such service comprises as much a part of hospital facilities as nursing care, specialized equipment or the physical plant. In

some states Blue Cross has declared its intent, however, to restrict future financial support to service alone. To whom, then, can the hospitals turn?

Universities are so over-extended in supporting pre-doctoral medical education it is unrealistic to look to them to finance the extensive post-doctoral education which a physician undertakes before beginning practice and which he must now repeat at regular intervals if he wishes to remain in practice. It has been tacitly assumed that the government would one day underwrite such costs, as they did formerly for clinical research. The government, however, at present seems disposed to decrease rather than increase its modest support

of post-doctoral education on the thesis that residencies and fellowships merely increase the specialization of physicians and hence add to their financial remuneration. As taxpayers we support such decisions, but as consumers we question whether they will not create an even greater shortage of health manpower and thus increase still further the economic fees of the highly specialized experts.

A stark example of the impact of decreasing financial support for all types of medical education is loss of the nominal participation of the Deaconess in the Harvard Family Practice program. In the last annual report the potential value of this type of program to the Deaconess was pointed out, as well as the possibility of losing financial support for our modest participation. This now has occurred at the very time a whole new generation of young doctors has begun to turn again to careers in the practice of family medicine rather than to the more esoteric aspects of subspecialty work and research. No further billets for Deaconess house officers will be available for the collaborative experimental program which combined the training requirements for accreditation in Internal Medicine with an equally broad base of experience in health care for the family as a unit.

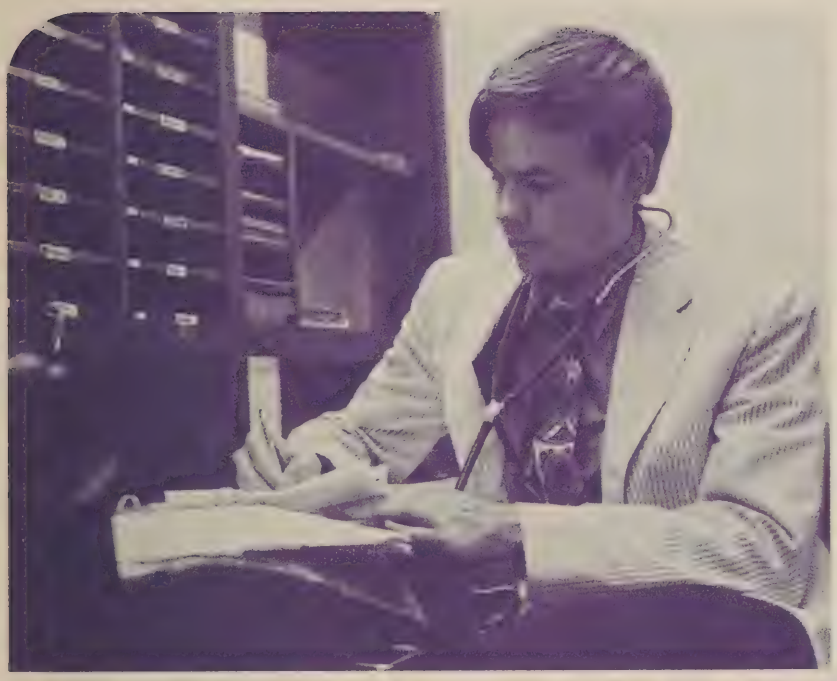
Time would seem ripe for the Deaconess to pioneer some new and imaginative fund raising program for the support of post-doctoral training and continuing medical education. Perhaps the profession itself should supply seed money for such purposes. It is not traditional for professionals either within or without the health field to provide the educational support for replacement of themselves. Yet the high cost of medical education which has followed the exponential growth in basic science may make this course essential.

Certainly the money cannot come from hospitals. Owing to steadily rising costs, hospitals have become the favorite scapegoat for sociologists, politicians, self-appointed experts in the communications media and even doctors themselves. All have joined to accuse the hospitals of an uncontrolled cost spiral. Yet many of the critics overlook the fact that what hospitals provide is what the public demands and physicians permit.

When the public insists that an institution offer emergency service 24 hours a day, 7 days a week to all who would seek it, costs will increase. When the public simultaneously insists that an institution provide the final earthly resting place for a relative who can die conveniently under the auspices of hospital nursing care and only inconveniently under family nursing care in the home, costs will increase. When a hospital installs a new generation of bramasheens and thermothrockles because a medical staff insists it otherwise cannot administer quality care, costs will increase. And when quasi-regulatory agencies and community action groups impose formidable administrative barriers which must be surmounted each time a change of service or effectiveness is attempted, costs will increase rather than come down under the very control such agencies were established to exert.

It behooves us to attack the forces which lead to such costs increases rather than the hospitals themselves where the result merely comes into focus. It also behooves the medical profession not to add further to the already over-burdened bed charge with a vast expense of continuing education.

It has been possible in a remarkably short span of years to build a strong, Deaconess-oriented house officer training program in medicine. As a result, the highest type of medical care can now be assured at all times, for all types of patients. As a further result, an increasing flow of young alumni who will constitute the next generation of practitioners will use the Deaconess as their referral center. This is an asset which the hospital should protect, but it may become one that also creates long-range funding problems which exceed the brick and mortar of the past.



The Department of Surgery

Cornelius E. Sedgwick, M.D.
Chairman

The consensus of our long-range planning committee, composed of trustees, members of the medical staff and administration, is to continue the New England Deaconess Hospital as a specialty referral hospital, serving patients with unusual and complicated problems not seen in a community type of hospital.

A specialty referral hospital is based on a highly skilled staff, working with a hospital administration willing to supply the necessary services, personnel and equipment to care for the more complicated medical and surgical problems. Medical school affiliation, pre-doctoral and postdoctoral teaching and medical research provide the necessary additional stimulation. I have reported on these aspects of our hospital in previous annual reports.

Each aspect of the basic structure must, of course, constantly be reviewed and strengthened. This year I would like to review the last five years' performance in a statistical manner, and to show our growth as a specialty hospital. A study of the past may help to plan for the future.

I have in mind particularly that since political, social and economic trends for future delivery of medical services will be determined by government regulation rather than by hospital policy, we cannot reliably predict how they will affect our continued growth as a specialty hospital. It is fair to assume, however, that if we maintain our devotion to excellent patient care and advance our skills and technique in diagnoses and therapy, patients will seek and demand our services. Therefore we can, I believe, project reasonable expectations for the future — and with some degree of certainty — by studying our past performance.

For review in this report, I have selected four surgical subspecialties: cardiothoracic, gynecology, arterial and genitourinary, including kidney transplantations.

1. The cardiothoracic section was formed some years ago by combining the established Overholt Thoracic Clinic program with the thoracic surgeons

from the general staff and the Lahey Clinic. The cardiothoracic residency program was reorganized. Two years ago, F. Henry Ellis, Jr., M.D., was made chief of this section.

This year we obtained full approval of our cardiothoracic residency program by the American Board of Thoracic Surgery — the only fully approved cardiothoracic residency program in the city of Boston.

There is an increase of thoracic, cardiac and esophageal operations during the period 1968 to 1973. A continuation of this curve surely assures us as a specialty hospital.

2. We have never had an organized section on gynecology. This year I appointed Clement Yahia, M.D., as chief of such a section. We rotate a general surgical resident to this service. Educational conferences, rounds, and so forth, have been organized. Collaborative studies and publications are planned in gynecologic cancer. The number of gynecological operations has doubled within the last five years.

3. Arterial surgery is now a subspecialty. Arterial surgery treats occluded arteries by removing the disease producing the occlusion (endarterectomy) or by removing the occluded segment of artery and replacing it with a graft. A large number of these cases come from the Joslin Clinic, as occluded arteries are frequently a complication of diabetes. We are organizing a residency training program in arterial surgery and plan to offer a one-year residency or fellowship in this discipline.

4. Genitourinary surgery has always been a strong section of surgery at the New England Deaconess Hospital. Cryosurgery (a method of freezing), renovascular surgery, renal dialysis and kidney transplant have steadily increased in both complexity of procedure and in number of cases.

Table 1 summarizes the growth in these four specialities of surgery, with a separate entry given to kidney transplants. The total number of all surgical procedures has increased from 5,430 operations in 1967-68 to 6,730 in 1971-72, or an increase of approximately 24 per cent. Increase in operative procedures means increase in other disciplines — medicine, pathology, laboratory and radiation (both diagnostic and therapeutic). If the past is a valid prognosticator of the future, we will remain a viable specialty referral hospital.

Table 1 Total Operations

	'67-'68	'68-'69	'69-'70	'70-'71	'71-'72
Genitourinary	646	631	495	1,053	1,125
Gynecologic	330	296	257	767	648
Arterial	152	159	201	181	228
Cardiac	58	65	80	168	201
Kidney Transplants	0	0	2	3	7
Other	4,244	4,094	4,288	3,793	4,521
Total Cases	5,430	5,245	5,323	5,965	6,730

The Department of Radiology

Mirle A. Kellett
Chairman

Construction is complete, the workers have gone, and now that the dust has settled we have a fine physical plant in which to carry out our diagnostic work. One might expect to settle into a fairly stable routine, but change is the order of the day. We must be alert to the challenges presented.

One major change we have made is to take over complete responsibility for the imaging procedures of nuclear medicine. The scanner, which weighs more than 4,000 pounds, was moved from Palmer Roof to Farr 2 into an area made available by consolidation of the urology suite. A full-time career nuclear medicine technologist was employed to operate the machine and it is now being utilized to its fullest capacity, performing an average of 33 scans per week. Further expansion of this program will require the acquisition of a second scanner.

Last year we anticipated a case load of between 35,000 and 37,000. The total number of examinations actually performed was 38,705. Fiscal 1973 should put us over the 40,000 mark. A mere five years ago the total number of cases was 26,000 and of these 6,000 were the small survey films which we ceased doing a year ago. We have doubled our volume of work in five years.

One of our areas of rapid growth is the field of angiography. This is the study of the blood vessels of an area or organ of the body by the placement of catheters into the proper area and injecting a substance visible on X-rays. The technique requires complex and sophisticated equipment. Besides the doctor performing the catheterization, a highly trained technician and an assistant are required. Some of the procedures take two hours or longer to complete. Because such vascular

examinations are requested by surgeons, urologists, neurosurgeons, gastro-enterologists and others the number is becoming more than can be performed in one room. Anticipating the need, we designed a new special procedures room during the addition to the hospital. Because of the high cost of X-ray machines, the room was not equipped when the building was completed. The time has come when we must give serious thought to the project so that we can serve the needs of the patients without long costly delays.

Ultrasonics is a fairly new field which seems to be growing in scope and importance under the aegis of the radiologist. The process consists of the production of vibrations or sound waves by pulses of high frequency current activating a piezo-electric crystal or transducer. These sound waves travel through liquids or solids until they collide with an interface of a different medium. An echo is produced which travels back and hits the crystal, generating an electric signal which can be recorded in several different ways — most commonly on an oscilloscope. The techniques are useful in certain neurosurgical, urological and cardiology studies. Because of the medical staff's interest in this diagnostic technique, we may soon need to set up a sub-section to perform these studies.

There are many other techniques becoming available in the field of diagnostic radiology. Some are interesting, a few are valuable; all are expensive. In an effort to control costs, one must evaluate all of the new techniques and adopt only those which will benefit the patient. Regional planning emphasizes the need to concentrate specialized services rather than having each hospital try to provide all costly services to each patient. Such a program already has been designed and implemented for X-ray therapy. We hope the inconvenience of transporting patients between hospitals for various specialized services will be compensated by improved care.

The Department of Pathology

Bradley E. Copeland, M.D.
Chairman

Fiscal 1972 has been a year of adjustment to the hospital expansion of 1971. Since the workload of the laboratories increased steadily each year before the expansion, it is not surprising that the addition of 100 beds accelerated the pressure and compounded the problem of cramped laboratory facilities.

Our laboratories are at maximal utilization 24 hours a day, 7 days a week. Evenings and nights find a wide variety of tests available at any time on a moment's notice.

Inspection by the College of American Pathologists and the Joint Commission on Accreditation of Hospitals confirmed the excellence of our service to patient care, but both emphasized the problem of overcrowded personnel in the laboratory. The hospital is planning a new building in response to this need for both increased space and a more efficient laboratory facility. Until the new building can be erected, various readjustments are being tried in an attempt to relieve some of the overcrowding.

In the past, the blood bank was too distantly separated from the operating rooms, source of the heaviest blood demand. This year, the blood bank has been moved closer to the operating rooms. Besides saving time and steps, the new quarters in the Deaconess building also have a more attractive and efficient space for blood donors. A blood donor insurance program for members of the hospital family has been instituted with an unusual feature that covers grandparents as well as children.

It is now possible to utilize equipment to freeze red blood cells for long term preservation. Already a number of patients are donating several pints of their own blood before the operation. This blood is frozen and held in deep freeze until needed at the time of the surgery.

The NEDH School of Blood Bank Technology is the first and only school of its kind in New England. It has successfully completed its first year under the guidance of Dr. Rosvoll, director, and Mrs. Mitsui, chief technologist. We are proud of this accomplishment.

The trend in chemistry and hematology is toward increased automation of frequently used measurements. In addition, rapid turn-around time of reports to physicians has been emphasized. Almost half of the chemistry tests are time related.

Our hematology laboratory has pioneered the evaluation of hematology quality control material for the Massachusetts Society of Pathologists. These materials are now in full use by a large number of hospital laboratories.

In cytology, the volume of specimens increases each year. The cytology of the urinary tract has grown to be a major part of the program. Exciting new possibilities are being investigated in the gastrointestinal tract as a result of some special techniques with the clinical use of the fiber optoscope.

In anatomical pathology, the number of surgical specimens was the largest in the history of the department. These specimens provide a graphic reflection of the shifting emphasis related to the kinds of special problems that confront all clinicians. For example, tuberculosis, which used to provide a large component of thoracic surgical specimens, is now an infrequent type of specimen. On the other hand, the number of open heart cases steadily increases. Formerly a large number of thyroid glands were removed surgically because of Graves disease and because of large adenomatous goiters. Now, because of better medical treatment for the former and both prevention and earlier diagnosis of the latter, very few surgical operations are needed. Thyroid tumors continue at a constant level, however. Sometimes a change in procedure accounts for the early diagnosis of disease formerly missed. Such is the reason for a considerably increased number of parathyroid tumors diagnosed early and removed because of the automated chemistry profile which identifies the altered calcium metabolism.

The electron microscope is becoming increasingly useful as a diagnostic tool, especially in certain circumstances. At present, it is useful diagnostically for only a very small percentage of surgical specimens, but the ultrastructural studies continue to contribute additional understanding of various processes.

After many years of effective leadership, Dr. William A. Meissner has stepped down from the administrative duties of the chairman to devote more time to teaching, investigation and the practice of pathology. He has been very active in the World Health Organization Committee on Diagnosis of Thyroid Tumors, an attempt to organize a meaningful international classification of thyroid tumors.

Dr. Bradley E. Copeland, our new chairman, received the Distinguished Service Award from the World Association of Pathology Societies for "distinguished service in the field of standardization methods, materials and nomenclature in clinical pathology."

Our department continues to be called upon by national professional organizations to provide leadership in educational programs:

Dr. Merle Legg has developed a very popular workshop in diabetic pathology which has been filled to capacity at two national meetings.

Dr. Raymond Maguire served as director of a training institute for the American Society of Clinical Pathologists. This was one of 20 nationwide sponsored institutes.

The Joint Center for Radiation Therapy

Samuel Hellman, M.D.
Chairman

The Joint Center for Radiation Therapy completed the fourth year of its existence in Fiscal 1972. During the year, 1,745 new patients were seen, an increase of 10 per cent over the previous year. Of the total number, 483 were seen at the New England Deaconess Hospital.

The member hospitals remain the Beth Israel Hospital, the Boston Hospital for Women, the Children's Hospital Medical Center, the New England Deaconess Hospital, the Peter Bent Brigham Hospital and the Faulkner Hospital, which is the first associate member. The staff numbers 62.

Our physical plant has expanded in two important areas. A new 12 MeV Linear accelerator has been installed at the Peter Bent Brigham Hospital and is expected to be operating for patients very shortly. It is much needed and should alleviate the excessive press on the present available facilities.

Perhaps the most significant and innovative expansion, however, is the new Radiation Therapy Treatment Planning Center at the Parkway Division of the Boston College for Women. This is, so far as we know, the only cooperative treatment planning center used by a number of hospitals. This

center has been operational since May and has been all that we hoped it would be.

All treatment planning for patients, regardless of where they are treated within the Joint Center, is done at the Treatment Planning Center. It is necessary for some patients to go to the Treatment Planning Center for at least an initial session. In the first five months of operation, the visiting patients numbered 283.

During the patient's visit, careful body contours are made and treatment plans determined with the use of computer assistance. The appropriate treatment plan is then rehearsed on the radiation therapy treatment simulator. This piece of equipment allows duplication of the radiation therapy treatment with diagnostic X-ray facilities so that we may follow the exact location of the radiation therapy beam using image amplification as well as X-ray filming. When this is satisfactory, the plan is then forwarded to the appropriate hospital for the patient's treatment.

In addition, certain devices for patient immobilization or beam modification are also constructed at the Treatment Planning Center. These devices allow modification of the beam for each patient's individual differences. In general, this operation has gone quite well and has resulted in a higher quality of radiation therapy being delivered to patients of the Joint Center.

The teaching activities of the Joint Center continue to expand. Our residency program has increased so that there are 11 residents who are fellows in training at the Joint Center for Radiation Therapy. In addition, our radiation therapy technology school has increased so that there are now six technologists in training. We continue to be the largest training program in radiation therapy for both physicians and technicians in the New England area. A combined program for radiological physics with the Harvard School of Public Health has been expanded and has recently been funded by the National Institute of Health.

The research activities of the Joint Center are performed primarily in the Shields Warren Radiation Laboratories. The areas of investigation — and some of the work in progress — are:

1. The nature of X-ray damage in mammalian cells and how such damage is repaired. Drs. James A. Belli and William Nagle have been studying the nature of damage inflicted by X-rays on mammalian cells in culture. They specifically have been investigating the DNA of such cells. This vital genetic material of the cells is clearly damaged by

radiation. But when allowed appropriate post-irradiation conditions, such cells appear to be able to repair some of this damage. Thus, these studies are actively concerned with the nature of X-ray damage to genetic material and how this is repaired. The information to be obtained is vital if we are to understand how to achieve maximum damage to tumor cells while at the same time preserving normal cells.

2. Immunology and pathophysiology of experimental ovarian carcinoma with a goal toward understanding the possible role of immunotherapy. Drs. Order, Knapp and Donahue have been studying an experimental ovarian carcinoma in mice. They have shown that this tumor has an associated antigen which is also found in normal fetal tissues but not in normal adult tissues. Further, that antisera made against it are effective in destroying tumor cells. Thus, they have developed an effective program of immunotherapy in the experimental animal. This program is further studied in the hope that it or a similar technique will be useful in humans.

3. Immunology of Hodgkin's disease. Drs. Order and Hellman have described the presence of common antigens on cells within Hodgkin's disease infiltrates. During the last year, these antigens have been partially purified. They have been shown to be present in normal fetal tissue as well as Hodgkin's disease. Study of them has required a variety of immunologic techniques and currently under active investigation is the possibility that such antigens are present in the blood of patients with Hodgkin's disease. If this is so and if they can be detected conveniently, it may be possible to develop a laboratory test for Hodgkin's disease.

4. Studies of the mechanisms of chemotherapy/X-ray interactions on cells *in vitro*. Drs. Piro and Belli have been studying the mechanisms of interaction between clinically used chemotherapeutic agents and X-ray to understand how best to combine these agents for maximum damage to tumors with minimum damage to normal tissue. An important finding has been that cells treated with the drug Actinomycin D appear to be more sensitive to radiation even when there has been a significant period of time between the drug treatment and radiation. This has important clinical significance as this drug is often combined with radiation in clinical situations.

5. Studies of the hematopoietic tissue response to X-ray and chemotherapy. This is an important dose limiting normal tissue. Drs. Chaffey, Nelson and Hellman have been studying the ability of the bone marrow to support the growth of hematopoietic cells, especially after they have been treated with X-ray. This is important if we are to understand the tolerance of dose limiting normal tissues and how such tolerance can be increased.

6. Studies of the biology of the normal and stimulatd lymphocyte. Drs. Timberlake, Belli, Order and Hellman have been studying lymphocytes under a variety of physiologic circumstances, including resting and proliferating lymphocytes. Such lymphocytes are investigated for their antigenicity, relationship to the antigens appearing in Hodgkin's disease, as well as their radiation sensitivity. Dr. Timberlake has shown in some preliminary experiments that the DNA or important genetic material of lymphocytes appears to be quite different from those of normal somatic cells. Further, it appears to respond to radiation in quite a different fashion. Such information can be of important practical benefit to patients since the lymphocyte appears to be an extremely sensitive cell to irradiation.

7. Research and development on the better utilization of linear accelerators. The work of the physics group under Dr. Bengt Bjarngard and Dr. Goran Svensson has been concerned with the better utilization of our supervoltage therapy equipment. Creative treatment planning has been achieved using the facilities of the Radiation Therapy Treatment Planning Center at the Boston Hospital for Women. A great source of activity at present is the development of appropriate therapeutic techniques using X-rays and electrons available from the new 12 MeV linear accelerator at the Peter Bent Brigham Hospital.

In summary, the clinical responsibilities of the Joint Center for Radiation Therapy continue to expand with the patient number now being by far the largest in New England. Facilities for proper treatment of patients have increased with a significant improvement in the quality of treatment planning and simulation owing to the Radiation Therapy Treatment Planning Center at the Boston Hospital for Women, as well as the installation of the new 12 MeV linear accelerator at the Peter Bent Brigham Hospital.

The training programs in radiation therapy continue to increase as is necessary to provide an enduring supply of radiation therapists and technologists for the medical community. The multidisciplinary laboratory activities of the Joint Center for Radiation Therapy have been expanded and a number of tumor-related activities are currently under active investigation, all related to the eventual goal of improved treatment for patients with malignant disease.

The Friends of Deaconess

Mrs. James T. Mountz
President

Seven years ago when I reported to you for the Friends, I could tell you how many cups of coffee had been consumed in the coffee shop, how many dozens of doughnuts and how many egg salad sandwiches had been eaten. The volume has grown too large for that now; gross receipts last year were $87,177.77. Expenses, however, were $75,677.86, so the profit is less than it used to be. The high cost of supplies and the rising cost of labor account for this. Volunteers have become more and more scarce and, probably inevitably, we have had to add two more paid workers to the staff. If any of you have ideas on attracting volunteers we would welcome them.

The gift shop has repaid the Friends all that it borrowed to stock the new large shop and is doing business at a great rate — $1,100 to $1,300 a week. The flower shop is operating in the gift shop and also doing very well.

The thrift shop is amazing in the amount of business it does. It offers everything from clothing to antiques and the volunteers who run it are completely dedicated.

The diversional therapy ladies are equally faithful and have covered all floors of the hospital during the summer as well as during the winter. They are offering new and interesting projects to the patients who greatly enjoy them.

In May there was a well attended luncheon for the Friends at The County Club. Mr. Lowry was the speaker. It is an annual event we wouldn't miss for he brings us up to date on hospital affairs.

The Christmas open house was held December 12. We should have counted our guests, but judging from the way the cider, coffee and cookies disappeared there must have been several hundred.

The Christmas bazaar was, as always, gay and cheerful. I never cease to wonder how more than $2,000 can be made in one morning. The nurse's white elephant table (this time, the odds and ends boutique) is responsible for much of the success, along with their candy table.

Sixty-three United Methodist Women's Societies contributed to the NEDH Nursing School Scholarship Fund.

The student volunteer program was expanded last year. The patient service department, the dietary department, the printroom and the pharmacy laboratory welcomed the services of junior high (from the age of 14 up), high school and college students.

We have copies of our printed report for 1971-1972 and these are available to all interested. According to Mrs. Shields Warren, treasurer, our profit for fiscal year 1972 is $4,073.43. I point with pride to the fact that we were able to give the hospital $100,000 for the new radiation program. (The Friends, by the way, now number 454, including 68 life members. We would welcome many more.)

This is my swan song as president of the Friends, and I look forward to more work for the Deaconess and heartily welcome our new president, Mrs. John Rowbotham.

New England Deaconess Hospital

Balance Sheet

SEPTEMBER 24, 1972 AND SEPTEMBER 26, 1971

ASSETS

UNRESTRICTED FUNDS

	1972	1971
CURRENT ASSETS:		
Cash	**$ 209,467**	$ 180,099
Temporary cash investments	**517,217**	228,318
Accounts receivable (less allowance for uncollectible accounts: 1972, $804,888; 1971, $280,049)	**3,511,988**	3,325,329
Grants receivable	**400,000**	440,818
Inventories of supplies — at cost	**297,783**	262,098
Prepaid expenses	**125,136**	164,577
Total current assets	**5,061,591**	4,601,239
TRUSTEE DESIGNATED FUNDS (Note 1):		
Cash (less in 1971, $500,000 advanced for plant additions)	**641,851**	1,876
Investments — at cost (market value: 1972, $577,321; 1971, $166,500)	**575,821**	165,113
Due from Restricted Funds		601,793
Total trustee designated funds	**1,217,672**	768,782
PROPERTY, PLANT, AND EQUIPMENT — at cost (Notes 2 and 3):		
Construction in progress	**503,346**	389,999
Land, buildings, and equipment — less accumulated depreciation: 1972, $9,325,826; 1971, $8,320,885	**20,670,812**	17,983,818
Total property, plant, and equipment	**21,174,158**	18,373,817
TOTAL	**$27,453,421**	$23,743,838

RESTRICTED FUNDS

SPECIAL PURPOSE FUNDS:		
Cash	**$ 187,251**	$ 175,974
Investments — at cost (market value: 1972, $509,102; 1971, $417,500)	**445,910**	321,581
Due from Unrestricted Funds		395,000
Grants receivable	**403,120**	334,851
Total special purpose funds	**$ 1,036,281**	$ 1,227,406
ENDOWMENT FUNDS:		
Cash	**$ 8,371**	$ 7,870
Investments — at cost or contributed value (market value: 1972, $2,935,964; 1971, $2,740,000)	**2,452,029**	2,037,824
Real estate, equipment, and furnishings — at cost, less accumulated depreciation: 1972, $892,469; 1971, $976,724 (Note 3)	**4,213,338**	4,674,668
Due from Unrestricted Funds		52,398
Total endowment funds	**$ 6,673,738**	$ 6,772,760
PLANT REPLACEMENT AND EXPANSION FUNDS:		
Temporary cash investments	**$ 133,634**	$ 28,092

See notes to financial statements.

LIABILITIES AND FUND BALANCES

UNRESTRICTED FUNDS

	1972	1971
CURRENT LIABILITIES:		
Accounts payable and accrued liabilities	**$ 2,330,830**	$ 2,092,784
Deferred revenue	**209,805**	207,845
Current mortgage note instalments (Note 3)	**72,004**	85,681
Due to Restricted Funds		447,398
Total current liabilities	**2,612,639**	2,833,708
DEFERRED REVENUE — Third-party reimbursement (Note 2)	**511,400**	368,000
MORTGAGE NOTE PAYABLE (Note 3)	**3,514,389**	537,150
NOTES PAYABLE TO BANK (Note 3)	**1,343,638**	1,865,000
FUND BALANCES (Note 1)	**19,471,355**	18,139,980
TOTAL	**$27,453,421**	$23,743,838

RESTRICTED FUNDS

SPECIAL PURPOSE FUNDS:		
Due to Unrestricted (Trustee Designated) Funds		$ 399,793
Accumulated gifts, bequests, and reserves for special purposes	**$ 661,511**	511,555
Unexpended research grants	**374,770**	316,058
Total special purpose funds	**$ 1,036,281**	$ 1,227,406
ENDOWMENT FUNDS:		
Mortgage notes payable (Note 3)	**$ 2,534,246**	$ 2,965,320
Due to Unrestricted (Trustee Designated) Funds		202,000
Fund balances	**4,139,492**	3,605,440
Total endowment funds	**$ 6,673,738**	$ 6,772,760
PLANT REPLACEMENT AND EXPANSION FUNDS:		
Fund balance	**$ 133,634**	$ 28,092

See notes to financial statements.

New England Deaconess Hospital

Statement of Revenues and Expenses

FOR THE FISCAL YEARS ENDED SEPTEMBER 24, 1972 AND SEPTEMBER 26, 1971

	1972	1971
PATIENT SERVICE REVENUE	**$25,429,874**	$19,935,922
LESS — Free care (net of related endowment fund income), provision for uncollectible accounts, contractual adjustments, etc.	**1,658,536**	515,370
NET PATIENT SERVICE REVENUE	**23,771,338**	19,420,552
OTHER OPERATING REVENUE — Transfer from special purpose funds	**862,368**	977,452
TOTAL OPERATING REVENUE	**24,633,706**	20,398,004
OPERATING EXPENSES:		
Professional care of patients:		
General	**5,750,510**	5,590,109
Special	**8,896,912**	6,902,990
Household and property	**2,063,549**	1,459,185
Dietary	**1,361,619**	1,218,613
General services and administration	**2,925,555**	2,572,925
Employees' benefits (Note 4)	**1,668,772**	1,422,985
Depreciation (straight-line method)	**1,059,931**	802,789
Research, etc.	**862,368**	977,452
Total operating expenses	**24,589,216**	20,947,048
INCOME (LOSS) FROM OPERATIONS	**44,490**	(549,044)
INTEREST EXPENSE	**228,450**	76,410
LOSS BEFORE NON-OPERATING REVENUE	**(183,960)**	(625,454)
NON-OPERATING REVENUE:		
From endowment funds	**120,199**	98,666
Donations and other distributions (net of expenses of development department)	**127,365**	72,879
From temporary investments, etc.	**44,624**	39,541
Total non-operating revenue	**292,188**	211,086
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	**$ 108,228**	$ (414,368)

See notes to financial statements.

New England Deaconess Hospital

Statement of Changes in Fund Balances

FOR THE FISCAL YEAR ENDED SEPTEMBER 24, 1972

		..... RESTRICTED FUNDS		
	Unrestricted Funds	Special Purpose Funds	Endowment Funds	Plant Replacement and Expansion Funds
BALANCE AT BEGINNING OF YEAR AS PREVIOUSLY REPORTED	$17,371,198	$1,394,395	$3,807,440	$ 28,092
RECLASSIFICATION OF TRUSTEE DESIGNATED FUNDS FROM RESTRICTED TO UNRESTRICTED FUNDS (Note 1)	768,782	(566,782)	(202,000)	
BALANCE AT BEGINNING OF YEAR AS RECLASSIFIED	18,139,980	827,613	3,605,440	28,092
INCREASES (DECREASES):				
Legacies, gifts, etc.	663,215	142,844	93,886	318,062
Central Building Fund receipts				281,395
Grants for specified purposes		907,180		
Net gain on sales of investment securities		45,059	330,074	
Gain on sale of real estate to Unrestricted Funds			130,492	
Investment income		20,869		701
Excess of revenues over expenses for the year	108,228			
Transfer to other operating revenue		(862,368)		
Total	18,911,423	1,081,197	4,159,892	628,250
INTERFUND TRANSFERS:				
Investment in buildings and equipment	559,932	(65,316)		(494,616)
Other		20,400	(20,400)	
BALANCE AT END OF YEAR	$19,471,355	$1,036,281	$4,139,492	$133,634

See notes to financial statements.

New England Deaconess Hospital

Statement of Changes in Financial Position of Unrestricted Funds

FOR THE FISCAL YEARS ENDED SEPTEMBER 24, 1972 AND SEPTEMBER 26, 1971

	1972	1971
FUNDS PROVIDED:		
Operations:		
Loss before non-operating revenue	**$ (183,960)**	$ (625,454)
Add items included in operations not requiring funds:		
Depreciation	**1,059,931**	802,789
Increase in deferred third-party reimbursement (Note 2)	**143,400**	108,500
Total from operations	**1,019,371**	285,835
Non-operating revenue	**292,188**	211,086
Total from operations and non-operating revenue	**1,311,559**	496,921
Unrestricted legacies, gifts, etc.	**663,215**	126,186
Increase in mortgage note payable (Note 3)	**3,049,243**	
Proceeds of notes payable to bank (Note 3)	**1,343,638**	1,865,000
Transfers from Restricted Funds	**559,932**	1,279,135
Total	**6,927,587**	3,767,242
FUNDS APPLIED:		
Additions to property, plant, and equipment	**3,860,272**	3,619,293
Reduction in mortgage note payable	**72,004**	85,681
Payment of notes payable to bank (Note 3)	**1,865,000**	
Increase in trustee designated funds	**448,890**	126,186
Total	**6,246,166**	3,831,160
INCREASE (DECREASE) IN WORKING CAPITAL	**$ 681,421**	$ (63,918)
SUMMARY OF CHANGES IN THE COMPONENTS OF WORKING CAPITAL:		
Increase (decrease) in current assets:		
Cash	**$ 29,368**	$ 178,963
Temporary cash investments	**288,899**	(917,866)
Receivables (net)	**145,841**	1,368,742
Inventories	**35,685**	5,345
Prepaid expenses	**(39,441)**	124,302
Total	**460,352**	759,486
Decrease (increase) in current liabilities:		
Accounts payable, etc.	**(238,046)**	(354,794)
Deferred revenue	**(1,960)**	(38,029)
Current mortgage note instalments	**13,677**	(3,343)
Due to Restricted Funds	**447,398**	(427,238)
Total	**221,069**	(823,404)
INCREASE (DECREASE) IN WORKING CAPITAL	**$ 681,421**	$ (63,918)

See notes to financial statements.

New England Deaconess Hospital

Notes to Financial Statements

FOR THE FISCAL YEAR ENDED SEPTEMBER 24, 1972

1. Principles of Accounting

The accompanying financial statements of the Hospital have been prepared in general accordance with recently published pronouncements of the Committee on Health Care Institutions of the American Institute of Certified Public Accountants. The principal change from prior reporting practice has been the reclassification of trustee designated funds from restricted to unrestricted funds and fund balances as of September 26, 1971 have been restated accordingly. The Hospital, however, is continuing its consistent practice of recording unrestricted legacies and gifts as credits directly to the balance of unrestricted funds.

For purposes of comparison, certain preceding year's amounts in the statement of revenues and expenses reflect reclassification of amounts previously reported.

2. Land, Buildings, and Equipment

The Hospital computes depreciation using the straight-line method. Under certain third-party reimbursement agreements, however, the Hospital uses accelerated depreciation to determine reimbursable costs and defers the revenue attributable to the excess of such depreciation over straight-line depreciation. Revenue thus deferred for the fiscal years ended September 24, 1972 and September 26, 1971 amounted to $143,400 and $108,500, respectively.

3. Long-Term Debt and Construction in Progress

The mortgage notes payable by the Hospital are due in instalments which (1) as to the unrestricted funds amount to $72,004 annually to November 1995 and (2) as to the endowment funds amount to $84,978 annually to January 1991. The Hospital's land and buildings, with the exception of research buildings and certain staff residences, are assigned under these mortgages.

Notes payable to bank represent temporary financing in connection with the completion of the Hospital's parking garage, the costs of which were transferred from construction in progress to land, buildings, and equipment during the year. These notes have been classified as long-term because the Hospital intends to replace them during 1972 with long-term financing.

Construction in progress at September 24, 1972 includes engineering and architectural fees in connection with the proposed construction of a laboratory and school of nursing. The Hospital also has construction commitments of approximately $200,000 for the completion of the parking garage.

4. Employees' Retirement Plan

The Hospital has a noncontributory retirement plan covering substantially all employees not over age 55 at date of employment. Under the plan the Hospital provides amounts necessary to provide for current costs and amortization of prior service cost over forty years. The provision for the years ended September 24, 1972 and September 26, 1971 were approximately $444,000 and $368,000 respectively, all of which had been paid to the plan trustee as of those dates.

Accountants' Opinion

New England Deaconess Hospital:

We have examined the balance sheet of New England Deaconess Hospital as of September 24, 1972 and the related statements of revenues and expenses, changes in fund balances, and changes in financial position of unrestricted funds for the fiscal year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying financial statements present fairly the financial position of New England Deaconess Hospital at September 24, 1972 and its revenues and expenses, changes in fund balances, and changes in the financial position of its unrestricted funds for the fiscal year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year (after reclassification of certain preceding year's amounts as explained in Note 1).

Haskins + Sells

November 17, 1972

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Henry S. Rogerson
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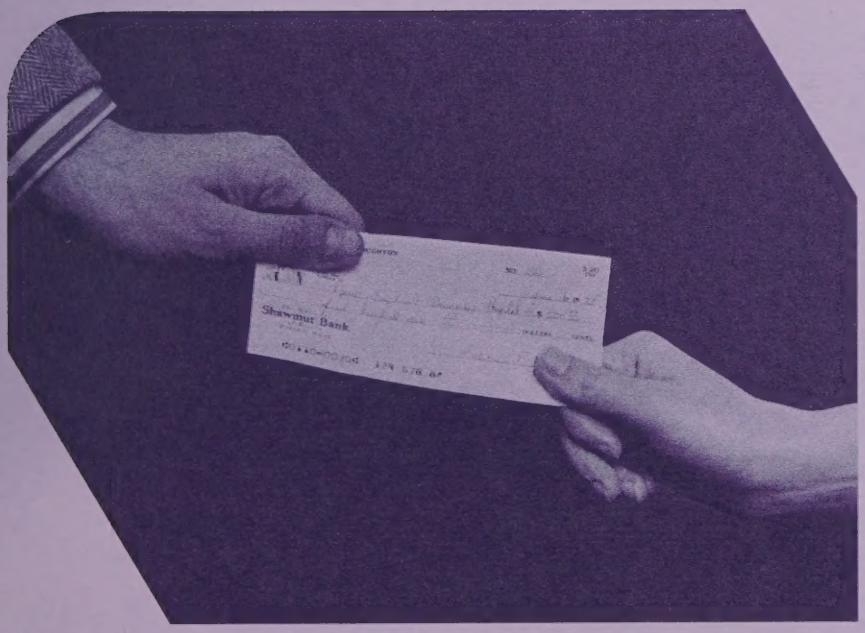

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